SOUTH DAKOTA OPIOID ABUSE NEEDS ASSESSMENT

South Dakota Department of Health

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South Dakota Opioid Abuse Committee

The following committee members provided significant input to the survey design: **Kristen Bunt, Sara DeCoteau, Maureen Deutscher, Dr. Chris Dietrich, Margaret Hansen, Captain Jon Schuchardt, and Brian Zeeb**

Strategic Partners

The following strategic partners distributed the online surveys to pharmacists and law enforcement personnel:
Staci Ackerman – South Dakota Sherriff Association
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Lori Martinec – South Dakota Police Chief Association
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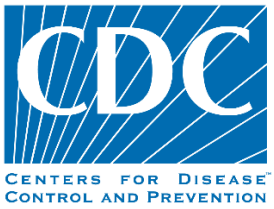


Funding for the Data Driven Prevention Initiative (DDPI) was provided by the Center of Disease Control. South Dakota Department of Health was awarded a three-year grant to conduct an opioid abuse needs assessment, strategic plan, and implementation plan.

BACKGROUND and RECOMMENDATIONS

Background. The South Dakota Department of Health (SD DOH) was awarded the *Prescription Drug Overdose: Data-Driven Prevention Initiative* planning grant from the Center of Disease Control (CDC) to support and build efforts to track and understand the full impact of opioid use and abuse in South Dakota. An Opioid Abuse Advisory Committee was formed in 2016 and is comprised of the following South Dakota organizations: DOH, Department of Social Services (SD DSS), State Medical Association (SDSMA), South Dakota Pharmacy Association, South Dakota Board of Medicine, Attorney General's Office, South Dakota Association of Healthcare Organizations (SDAHO), Indian Health Services (HIS), tribal health, Volunteers of America (VOA), and legislators. The purpose of the grant is to a) conduct a needs assessment; b) complete a strategy plan to identify needs and strengthen South Dakota's capacity to prevent misuse/abuse of opioids; and c) develop a data strategy to enhance and integrate current surveillance efforts for more accurate, timely data.

In addition, SD DSS received the SAMHSA State Targeted Response to the Opioid Crisis Grant (Opioid STR). The purpose of the grant program is to: (a) increase access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) including prescription opioids as well as illicit drugs such as heroin; (b) supplement current opioid activities; and (c) support a comprehensive response to the opioid epidemic using a strategic planning process to conduct needs and capacity assessments.

The purpose of this needs assessment is to fulfill to inform the strategic plans that will drive both the SD DOH CDC grant and SD DSS SAMHSA grant activities as well as strategic stakeholder tactical plans in addressing opioid abuse and misuse.

Recommendations. Although South Dakota ranks low in opioid-related deaths relative to other states, the trends for deaths have increased in 2013 - 2014. In order to get in front of the opioid abuse issue, the Opioid Abuse Advisory Committee is using several evidenced based practices and guidelines to develop the strategic plan. An important resource is the National Governors Association (NGA) Opioid Road strategies and tactics for states to adopt when addressing the opioid epidemic. When designing the needs assessment, the Committee referred to the strategies to establish a baseline.

One NGA health care strategy is the Prescription Drug Monitoring Program (PDMP). The results section outlines the most prescribed drugs, number of prescriptions, and number of users signed up. Hydrocodone Bitartrate/Acetaminophen is the most prescribed drug.

State agencies graded each NGA strategy to determine the status in the state. The PDMP and the Public Safety Strategies for Reducing the Illicit Supply of and Demand for Opioids strategies were graded as "B" or "in place and gaining momentum." The remaining strategies had a lower grade.

Professional stakeholders provided several suggestions for the Opioid Abuse Committee to consider. Below are identified strategic priority themes:

Prescribing Practices. Establish and educate providers on guidelines and alternatives to treat non-cancer pain.

Prescription Drug Monitoring Program (PDMP). Increase number of providers who review patient report prior to prescribing, integrate PDMP access with electronic health records, train and educate providers and law enforcement personnel on PDMP reports and processes, and provide access to PDMP data from surrounding states.

Training and Education. Provide training on opioid abuse recognition and testing. Offer training to addiction therapists to treat individuals with opioid use disorder. Provide training to pharmacists and providers of how to work with investigators during fraudulent investigations.

Professional Collaboration and Communication. Provide awareness of substance use disorder counseling and treatment agencies and develop processes for case management across professional lines.

Treatment. Increase statewide treatment capacity to treat opioid use disorder, particularly inpatient and Medication Assisted Treatment (MAT). Create awareness of local and regional counseling and treatment agencies and community resources.

Prevention and Public Education. Provide public education to South Dakotans regarding risks and signs of opioid abuse as well as resources to prevent addiction.

This report is accompanied by 11 appendices that provide further detail to each assessment component. If the reader has further questions regarding the needs assessment, refer to the appropriate appendix.

METHODOLOGY

The needs assessment design was a collaborative effort between the SD DOH, SD DSS, the Advisory Committee members, and Sage Project Consultants. The design was reviewed and approved by the CDC. The needs assessment design included the following methods:

- Death Certificate Data
- Outpatient and Inpatient Hospital Discharge Data
- Prescription Drug Monitoring Program
- National Governors Association Strategy Assessment
- Stakeholder Surveys

Refer to **Appendix A – Needs Assessment Design** for a comprehensive discussion regarding the design, methods, sampling, and instruments.

Surveys were sent to the following professional stakeholders: pharmacists, medical and dental providers, criminal justice, and substance use disorder counseling and treatment agencies. The survey instruments used questions from previous prevention and PDMP surveys. Target audience professionals tested all surveys. Patient and family surveys were designed; however, the IRB approval through University of South Dakota is pending. The Advisory Committee acknowledges the critical importance of attaining feedback from this target audience. Feedback from patients and families will be incorporated by the CDC DDPI and SAMHSA STR grants as both programs progress.

Prior to designing the needs assessment, needs assessment outcomes and a program logic model were outlined. Programmatic impacts were measured using a formative and summative evaluation plan providing a baseline data to measure interventions point forward. The comprehensive needs assessment included the following outcomes:

- An environment scan/asset map of substance use disorder (SUD) counseling and treatment providers and agencies;
- A gap analysis of the SUD continuum of care based ASAM levels of care;
- Status and gap identification of referral processes;
- Assessment of PDMP system efficacy;
- Identification of training needs across criminal justice, behavioral health, medical, dental, and pharmacy professions;
- Analysis of SUD professional workforce needs;
- Status of implementation of National Governor's Association strategies;
- Identification of patient barriers to care; and
- Understanding of trends from hospital, emergency room, and death certificate data.

The needs assessment findings will inform the statewide strategic plan. The logic model outlined below drives the evaluation components.

Table 1: Logic Model

Inputs	▪ CDC DDPI funding ▪ SAMHSA STR funding ▪ Statewide stakeholders ▪ Advisory Committee ▪ Existing data infrastructure (e.g., PDMP, hospital/healthcare, law enforcement) ▪ Agency partners including but not limited to health care, pharmacies, behavioral health, and law enforcement
Activities	▪ Alert potential misuse through PDMP surveillance system. ▪ Write guidelines for opioid prescribers. ▪ Provide education to professionals including but not limited to addiction therapists, prescription providers, pharmacists, and law enforcement. ▪ Provide education and awareness to opioid users and public. ▪ Respond to opioid users who misuse or abuse drugs. ▪ Provide recovery options for opioid users. ▪ Provide support to family members.
Outputs	▪ Policies that support surveillance, prevention education, response, and recovery ▪ Processes and systems that support surveillance, prevention education, response, and recovery ▪ Educated and equipped professionals including but not limited to addiction therapists, prescription providers, pharmacists, and law enforcement. ▪ Educated opioid users who do not misuse or abuse opioids ▪ Educated family members
Outcomes	▪ Reduced hospitalizations due to opioid misuse and abuse ▪ Reduced deaths due to opioid misuse and abuse ▪ Less cost to healthcare system

The program logic model will be updated as the project continues and becomes sustainable programming within state agencies and strategic partners.

RESULTS

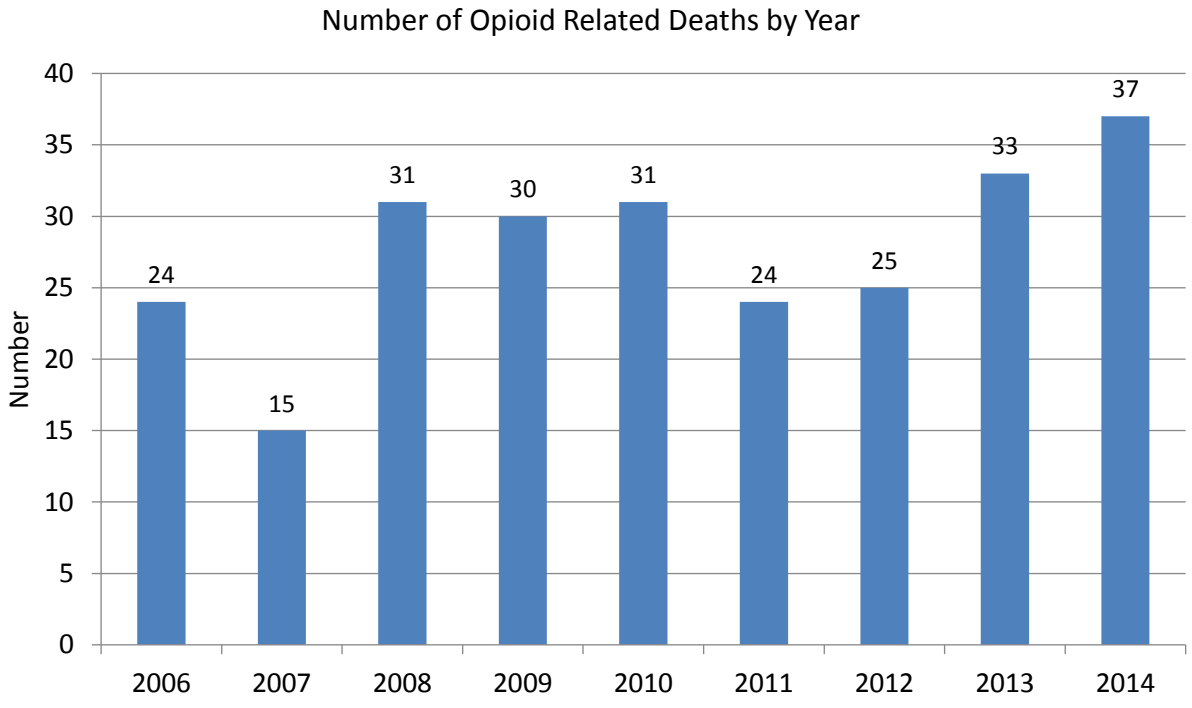
This section highlights findings from each method. Refer to Appendices B – K for a complete set of results including survey cross-tabulations, needs assessment design, and key terms.

DEATH CERTIFICATE DATA

The SD DOH Office of Data, Statistics and Vital Records maintains the vital records system for the state including death certificates. The report includes primary causes of death. SD DOH and the Advisory Committee acknowledge the questionable accuracy of death certificate data reported in literature and the lack of timely laboratory confirmation (e.g., toxicology reports) can limit the usefulness of death certificate data. While the Vital Records Office does work with physicians to assist with cause of death coding, further communication and training may be needed. For example, the primary cause of death may be recorded as cardiac arrest; however, the underlining cause of the death may be opioid abuse.

Deaths due to opioids increased from a rate of 3.2 in 2006 to 4.5 per 100,000 in 2014. Of those deaths, 45.6% were female and 54.4% were male. Over eighty-two percent (82.4%) were white and 16.8% were American Indian. Age groups most impacted by opioid related deaths were ages 45 – 54, 25 – 34, and 35 – 44 in that order. Figure 1 shows opioid related deaths by year.

Figure 1: Number of Opioid Related Deaths by Year



Source: South Dakota Department of Health Vital Statistics

South Dakota ranked 2nd lowest in the nation for age-adjusted rate of drug overdose deaths per 100,000 in 2015 (ranked 3rd lowest in both 2013 and 2014 *(MMWR/Dec 30, 2016).*

- 2015 – 8.4 (65 deaths) (U.S. rate – 16.3)
- 2014 – 7.8 (63 deaths) (U.S. rate – 14.7)
- 2013 – 6.9 (55 deaths) (U.S. rate – 13.8)

South Dakota drug poisoning death rate per 100,000 (2010-2014) was 7.8 (U.S. rate – 14.7) (45th in nation) *(CDC NVSS Multiple Cause of Death File, 2010-2014).*

County- Level Data. The data shown in the Table 1 below reflects deaths in 2012 – 2016. Any county not shown has less than 3 deaths and the numbers had to be suppressed.

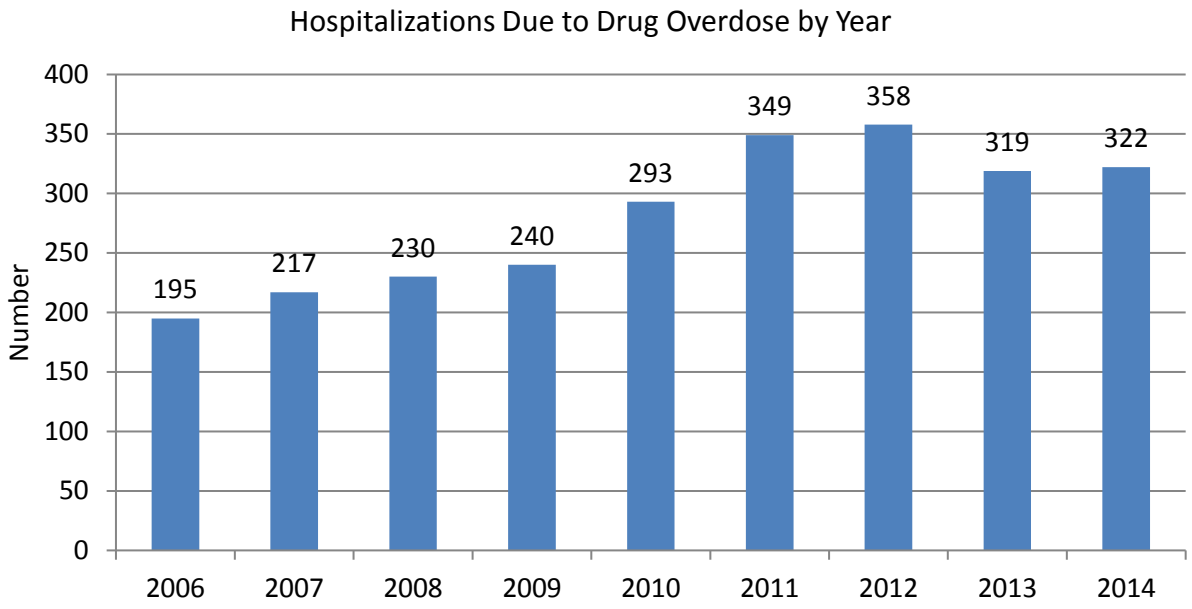
Table 2: Opioid Deaths by County in 2012 - 2016

	Deaths	Rate
South Dakota	147	3.5
Beadle	4	4.4
Brookings	6	3.6
Brown	6	3.1
Brule	3	11.3
Davison	5	5.0
Lawrence	5	4.0
Lincoln	5	1.9
Meade	7	5.2
Minnehaha	45	4.9
Pennington	21	3.9
Todd	4	8.0
Yankton	4	3.5

HOSPITALIZATION DATA

During the period of 2006 – 2014, there were 2,523 hospitalizations due to drug overdose. The hospitalization data only refers to overnight stays and does not include emergency room or clinic visits. Figure 2 shows hospitalizations due to drug overdose by year.

Figure 2: Hospitalizations due to Drug Overdose by Year



Death certificate and hospitalization data can be found in **Appendix B – Mortality and Hospitalization Data.**

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

The Prescription Drug Monitoring Program (PDMP) continues to be among the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at risk. South Dakota (SD) ranks 45th of the 50 states and District of Columbia with a prescribing rate of 66.5 prescriptions per 100 residents. The U.S. rate is 82.5 prescriptions per 100 residents.

The SD PDMP was established by the State Legislature in 2010 (SDCL 34-20E) and became operational in March 2012. Refer to **Appendix C – South Dakota Prescription Drug Monitoring Program**.

Table 3: Count of Prescription Records

Count of Prescription Records	Total
July 1, 2011 - December 31, 2011	411,326
January 1, 2012 - December 31, 2012	1,101,417
January 1, 2013 - December 31, 2013	1,152,900
January 1, 2014 - *December 31, 2014	1,211,367
January 1, 2015 - December 31, 2015	1,297,804
January 1, 2016 - December 31, 2016	1,339,076
January 1, 2017 - May 31, 2017	530,397
Total	**7,044,287**

Table 4: Most Prescribed Drugs | May 2017

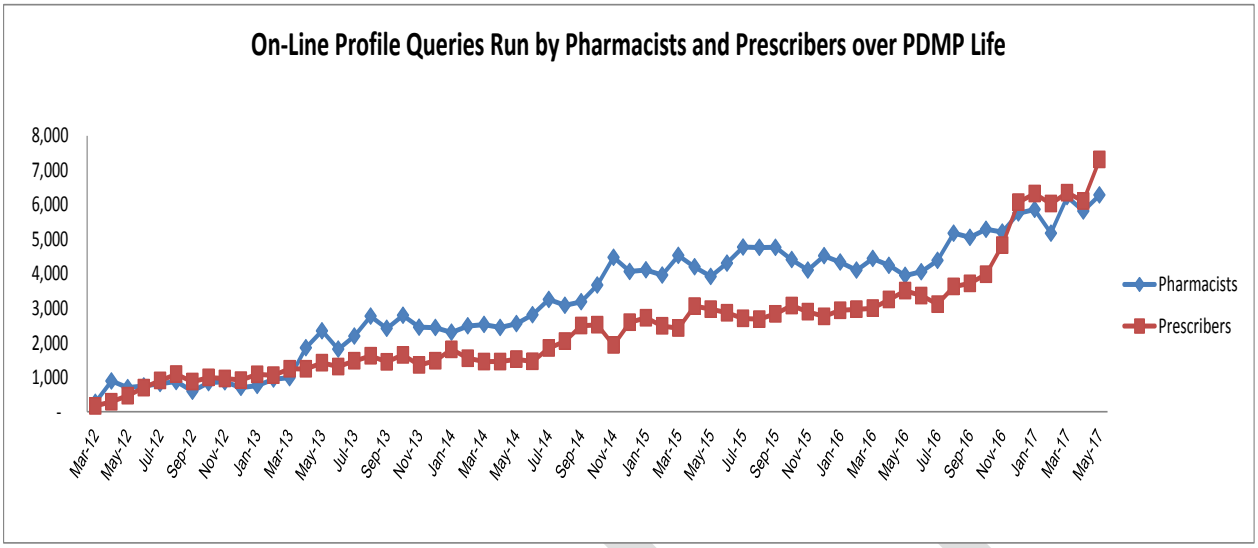
May Most Prescribed Drugs	RX's	Quantity	Days Supply	Quant/Rx
HYDROCODONE BITARTRATE/ACETAMINOPHEN	15,992	978,903	212,989	61
TRAMADOL HCL	10,860	874,809	212,089	81
ZOLPIDEM TARTRATE	6,887	239,382	237,506	35
CLONAZEPAM	6,528	416,791	214,431	64
DEXTROAMPHETAMINE SULF-SACCHARATE/AMPHETAMINE SUL	6,410	370,149	242,378	58
LORAZEPAM	6,256	339,231	163,730	54
ALPRAZOLAM	5,002	309,822	142,628	62
METHYLPHENIDATE HCL	4,917	255,355	180,242	52
OXYCODONE HCL	3,701	314,534	74,612	85
LISDEXAMFETAMINE DIMESYLATE	3,499	135,719	131,748	39

With passage of SB 1, effective July 1, 2017, South Dakota requires prescribers with an active SD CSR to register with the PDMP (veterinarians are exempted). The Board of Pharmacy and the Department of Health are working together to ensure all active SD CSR holders are aware of the requirement and are compliant with SB 1.

Table 5: Number of PDMP Users

Approved for Access		% Of
2012 Total	*1,253*	
2013 Total	*432*	
2014 Total	*371*	
2015 Total	*362*	
2016 Total	*663*	
Pharmacists	1115	91%
Physicians	1149	44%
Physician Assistants	400	74%
Nurse Practitioners	417	63%
Dentists	131	29%
Other	222	
Designated Agents	551	
Total	**3,985**	
Prescribers Querying	30%	
Pharmacists Querying	33%	

FIGURE 3: Trending PDMP Usage



NATIONAL GOVERNORS ASSOCIATION OPIOID STRATEGY ASSESSMENT

As noted in the Executive Summary, the framework of the NGA opioid strategies will provide a framework for the South Dakota Opioid Abuse Strategic Plan. Although health care strategies will be the focus of the CDC DDPI and SAMHSA STR programs, the Advisory Committee also reviewed public safety strategies, particularly those that overlapped with health care and behavior health care professionals. The SD DOH, SD DSS, and Division of Criminal Investigation (DCI) assessed strategies under their scope of work and assigned the status of each NGA strategy:

- In place and being implemented
- In place and gaining momentum
- In place and slow progress
- Being considered but not in place
- No action at this time

The state agencies believed there was room for improvement for all strategies so did not grade any of them at "in place and being implemented." The Advisory Committee will prioritize NGA health care strategies and monitor them annually to ensure progress is made. Figures 4 – 7 outline where each NGA strategy was placed in a baseline assessment. Refer to **Appendix D – National Governors Association Strategy Grades.**

Table 6: Health Care Strategies for Prevention and Early Identification Grades

In Place and gaining momentum	• Maximize the use and effectiveness of state PDMPs.
In place and slow progress	• Develop and update guidelines for all opioid prescribers. • Use public health and law enforcement data to monitor trends and strengthen prevention efforts
Being considered but not in place	• Develop and adopt a comprehensive opioid management program in Medicaid and other state-run health programs. • Expand access to non-opioid therapies for pain management. • Enhance education and training for all opioid prescribers. • Raise public awareness about the dangers of prescription opioids and heroin
No action	• Limit new opioid prescriptions for acute pain, with exceptions for certain patients. • Remove methadone for managing pain from Medicaid preferred drug lists.

Table 7: Health Care Strategies for Treatment and Recovery

In Place and gaining momentum	
In place and slow progress	• Create new linkages to evidence-based MAT and recovery services.
Being considered but not in place	• Change payment policies to expand access to evidence-based medication assisted treatment (MAT) and recovery services. • Increase access to naloxone. • Expand and strengthen the workforce and infrastructure for providing evidence-based MAT and recovery services. • Reduce stigma by changing the public's understanding of substance use disorder.
No action	• Consider authorizing and providing support to syringe service programs.

Table 8: Public Safety Strategies for Reducing the Illicit Supply of and Demand for Opioids

In Place and gaining momentum	• Establish a collaborative information sharing environment that breaks down silos across state agencies to better understand trends, target interventions and support a comprehensive state response. • Leverage assets from partner entities to improve data collection and intelligence sharing to restrict the supply of illicit opioids. • Expand law enforcement partnerships and data access to better target over-prescribers. • In narcotics investigations, implement best practices and ensure intergovernmental cooperation. • Establish and enhance stakeholder coalitions.
In place and slow progress	
Being considered but not in place	
No action	• Expand statutory tools for prosecuting major distributors.

Table 9: Public Safety Strategies for Responding to the Opioid Crisis

In Place and gaining momentum	
In place and slow progress	• Strengthen pre-trial drug diversion programs to offer individuals the opportunity to enter substance use treatment. • Ensure compliance with Good Samaritan laws.
Being considered but not in place	• Empower, educate, and equip law enforcement personnel to prevent overdose deaths and facilitate access to treatment. • Reinforce use of best practices in drug treatment courts. • Ensure access to MAT in correctional facilities and upon reentry into the community.
No action	

STAKEHOLDER SURVEY

Opioid abuse prevention and response strategies require collaboration from cross-functional professionals including pharmacists, medical and dental providers, criminal justice, and substance use disorder counseling and treatment agencies. In order to assess the status of current programming and attain the advice of professionals working with individuals with opioid misuse/abuse issue, a survey was administered in March and April 2017. The results are grouped under broad themes. For detailed responses, refer to **Appendices E – Pharmacist; F – Medical and Dental Providers; G – Criminal Justice; H – Accredited Substance Use Disorder Agency; I – Substance Use Disorder Agencies not accredited through the state; and J – Substance Use Disorder Counseling and Treatment Agency Asset Map.**

PRESCRIPTION DRUG MONITORING PROGRAM

The NGA recognizes PDMP as an important strategy to mitigate abuse and fraudulent access of opioids. The South Dakota Board of Pharmacy manages the PDMP program across the state. The PDMP software, PMP AWARxE, was developed by Appriss Health. In October 2016, Appriss deployed a survey to PMP AWARxE users when they accessed the software. Although, this survey did not ask what profession the respondent represented, the Board of Pharmacy determined most were pharmacists due to the content of the open ended responses. Two hundred (200) responded to the October survey.

The surveys deployed to the medical and dental providers and criminal justice stakeholders used the same survey instrument language so answers could be compared. The pharmacist survey included PDMP questions but not duplicative of the Appriss survey.

Satisfaction. Overall, those who use the PDMP platform are satisfied with the ease of use and would recommend use to their colleagues. Pharmacists were most comfortable and use the PDMP. Below are satisfaction results from the Appriss survey and the survey designed for this needs assessment.

TABLE 10: PDMP Satisfaction

	Appriss Health Survey Primarily Pharmacists	Opioid Abuse Survey Providers	Opioid Abuse Survey Criminal Justice
Recommend to colleagues	75%	60%	42%
Very user friendly	66%	42%	41%
Essential to their practice or work	78%	54%	47%

Usage. The survey was deployed prior to SB 1, effective July 1, 2017, which required prescribers and dispensers with a controlled substance registration to be enrolled in PDMP (veterinarians are exempted). At the release of this report in July 2017, approximately 3,985 users are signed up. The Appriss survey indicated 48% of respondents perform a patient request in PMP AWARxE once a week or

more. In the needs assessment survey, 37% of pharmacists, 23% of medical and dental providers, and 2% of criminal justice stakeholders access the PMP AWARxE once a week or more.

Influence in prescription and dispensing. Of those who responded to the Appriss survey, 86% indicated patient reports changed their intention of prescription or dispensing a controlled substance to a patient. Of those who responded to the opioid abuse survey, 86% of pharmacists and 75% of medical and dental providers have been influenced by PDMP patient reports.

Strategies. The respondents were asked how to make the PDMP process more effective. They provided the following suggestions.

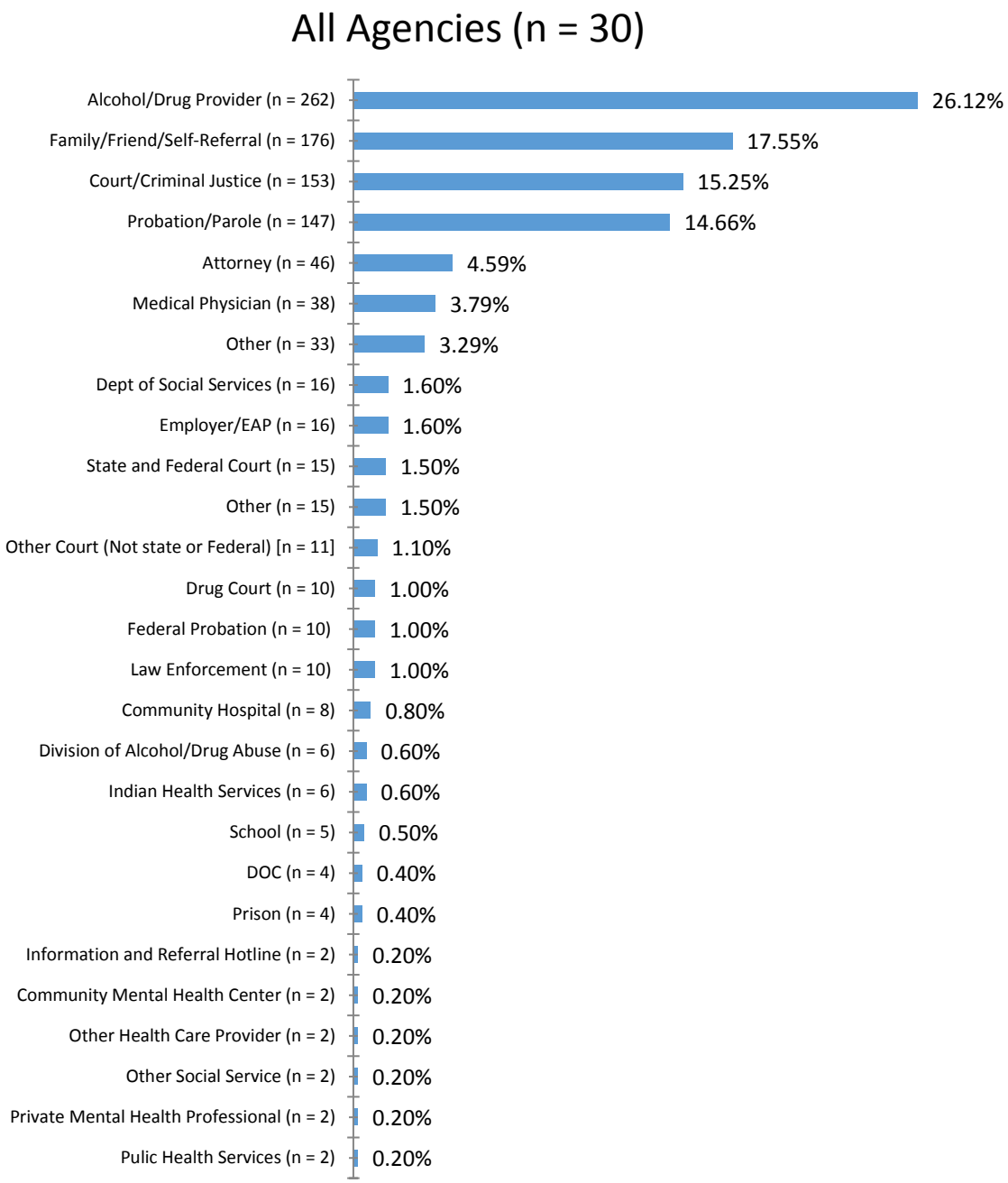
- **Increased use**. Respondents, particularly pharmacists, requested more medical and dental providers use the PDMP platform prior to releasing prescriptions to patients who are flagged on their patient report.
- **Electronic Medical Record (EMR) Integration**. Medical providers suggested integrating the PMP AWARxE access into the health care facilities' EMR systems.
- **Training.** Additional training on the PMP AWARxE software and PDMP process were requested by medical/dental providers and criminal justice professionals.
- **Access to surrounding states**. Several respondents noted patients cross state lines to access prescriptions. Forty-one (41) states, including SD, have the same operating system – PMP AWARxE - so key stakeholders can further investigate sharing information between those states. No barrier in South Dakota law that prohibits interoperability.

OPIOID MISUSE/ABUSE PATIENT REFERRAL SOURCES

Accredited treatment agencies were asked to indicate the number of patients who were specifically referred to services based on opioid misuse/abuse. The primary source of referral for opioid use disorder treatment was another treatment who assessed the patient and referred to another treatment agencies who may have a higher continuum of care or have more appropriate services. When combined, court/criminal justice; probation/parole; and attorneys were the largest referral source reported. Combined, they accounted for 34.5% of the total referrals reported for opioid use disorder. Family and self-referrals are also one of the top three referral sources of opioid use disorder patients to counseling and treatment. Referral from medical providers accounted for 3.79% of the referrals reported. Figure 7 shows all referral sources broken out by percentages.

Accredited treatment agencies also indicted they are seeing more experimentation of opioids combined with other substances and starting to see heroin in their communities; however, 7 of the 30 respondents reported seeing no changes in the referral area.

Figure 8: Opioid Use Disorder Referral Sources



OPIOID USE DISORDER PATIENT DEMOGRAPHICS IN TREATMENT

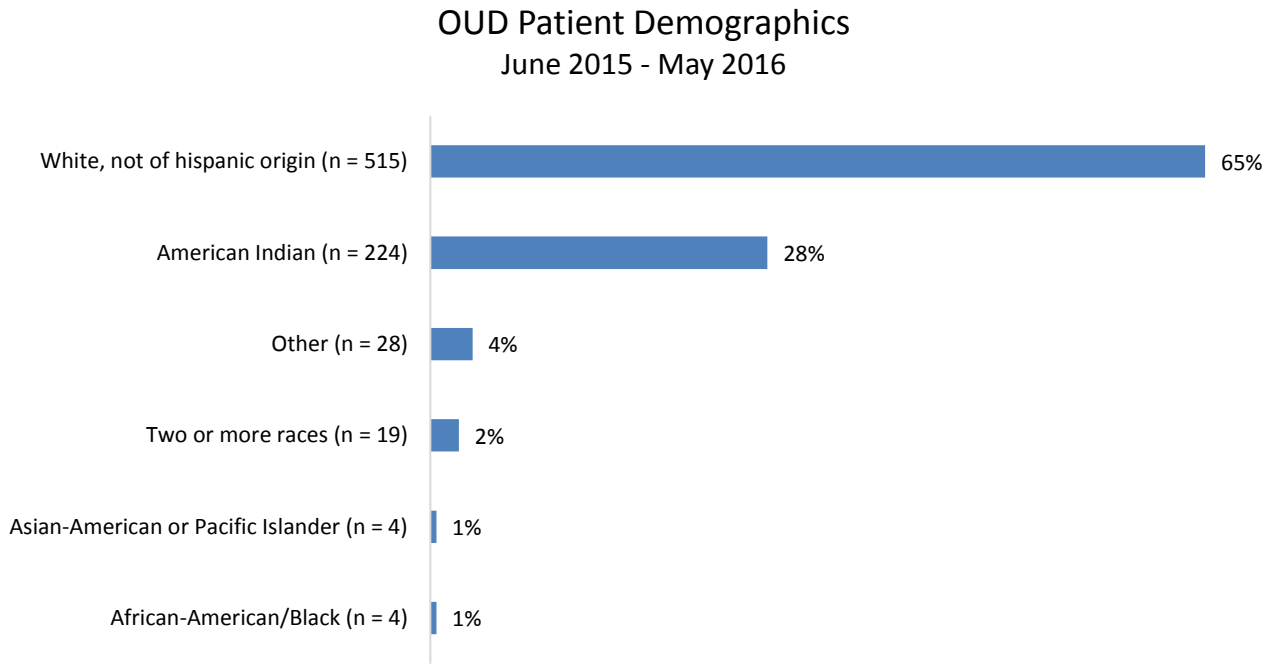
Accredited treatment agencies were asked to provide demographics on the opioid use disorder (OUD) patients they served. The following statistics and figures reflect aggregated data across the 30 of 40 accredited treatment agencies that replied to the survey. Note that the demographic numbers range from 672 – 797 as some agencies did not have all demographic data.

Accredited agencies reported 55% of their patients with opioid use disorder were females and 45% were males. Thirty-five percent (35%) of the patients were in the age range between 25-34 years with the next largest group being 35-44 years of age (23%). Sixty-five percent (65%) of patients are white and 28% are American Indian (Figure 9).

Agencies reported 27% of the patients obtained opioids through a prescription; 27% through prescribed drugs obtained "on the streets"; 10% through prescribed drugs to their family members; for 35% the means was not known or other and two patients were reported to obtain through fraudulent prescriptions. (Figure 10)

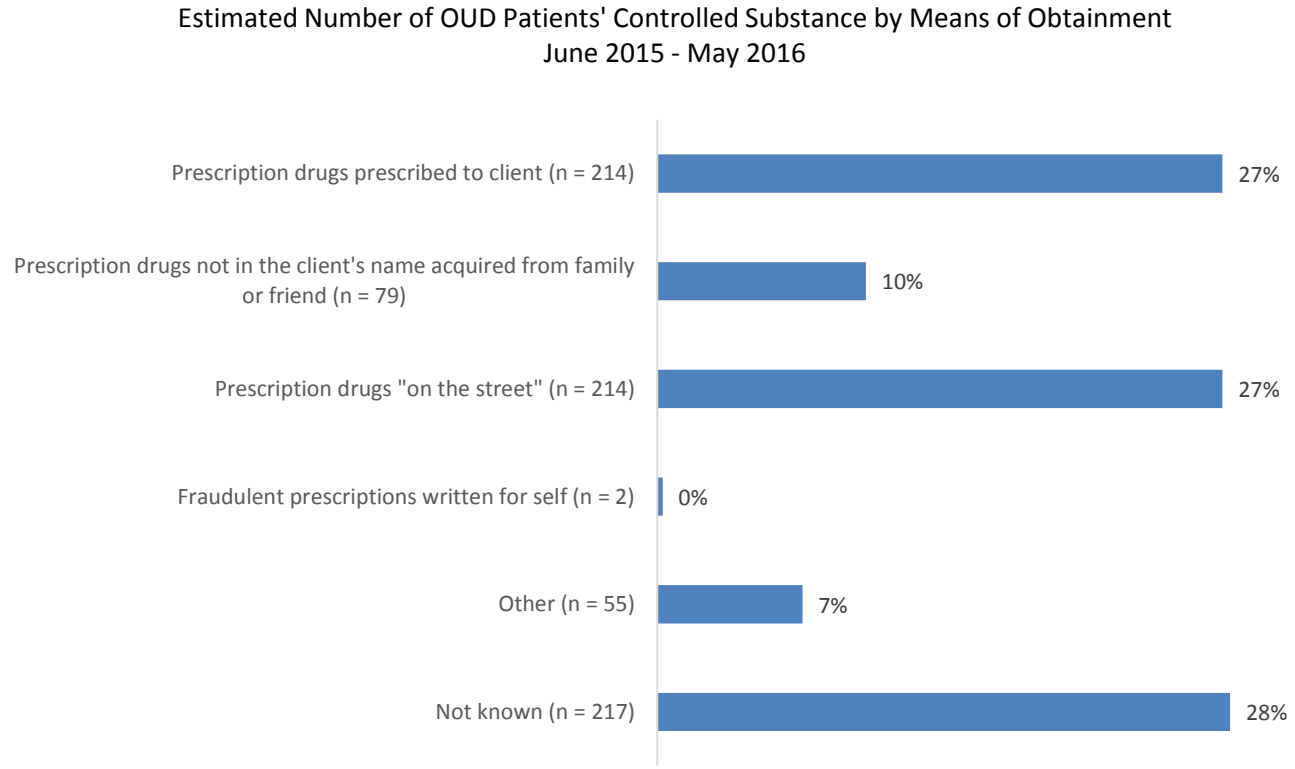
The drug of choices was Oxycodone (37.71%); Hydrocodone (36.64%); Fentanyl (9.92%); Codeine (7.18%); Morphine (5.50%); Methadone (1.37%); Hydromorphone (1.07%); and Meperidine (.61%).

Figure 9: Opioid Use Disorder Patient Ethnic Background



Agencies were asked to check all that apply for the following two questions.

Figure 10: Estimated Number of OUD Patients' Controlled Substance by Means of Obtainment



Both judicial officials and law enforcement identified opioids as gateway drugs, which could lead to other drugs use (e.g., meth) and crimes, such as theft, to support their habit.

PROFESSIONAL RELATIONSHIPS and COLLABORATION

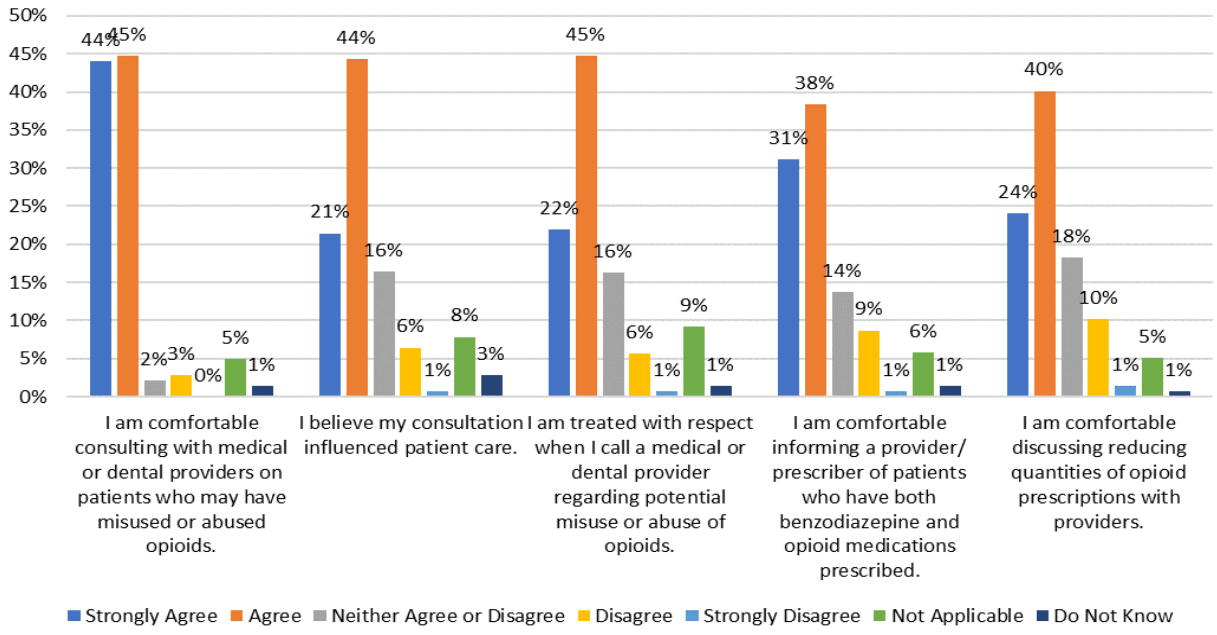
Pharmacists, medical and dental providers, and criminal justice professionals were asked their comfort and knowledge levels in collaborating with each other to prevent and investigate opioid misuse and abuse and referring individuals to substance use disorder counseling and treatment agencies. The recommendations to this set of questions are as follows:

- ***Referrals.*** Increase referrals to substance use disorder counseling and treatment agencies by increasing awareness of agencies and treatment efficacy to medical and dental providers and pharmacists.
- ***Communication.*** Create communication case management processes between medical providers, addiction counselors, and criminal justice professionals to ensure individuals receive continuum of care to overcome addiction.

- ***Training***. Train medical providers, addiction counselors, criminal justice professionals, and pharmacists regarding investigative process, particularly HIPAA guidelines.
- ***Process*.** Reinforce processes of consulting each other regarding PDMP red flags, fraudulent prescriptions, and prescription questions.
- ***Comfort.*** Increase trust and comfort of working in cross-professionally.

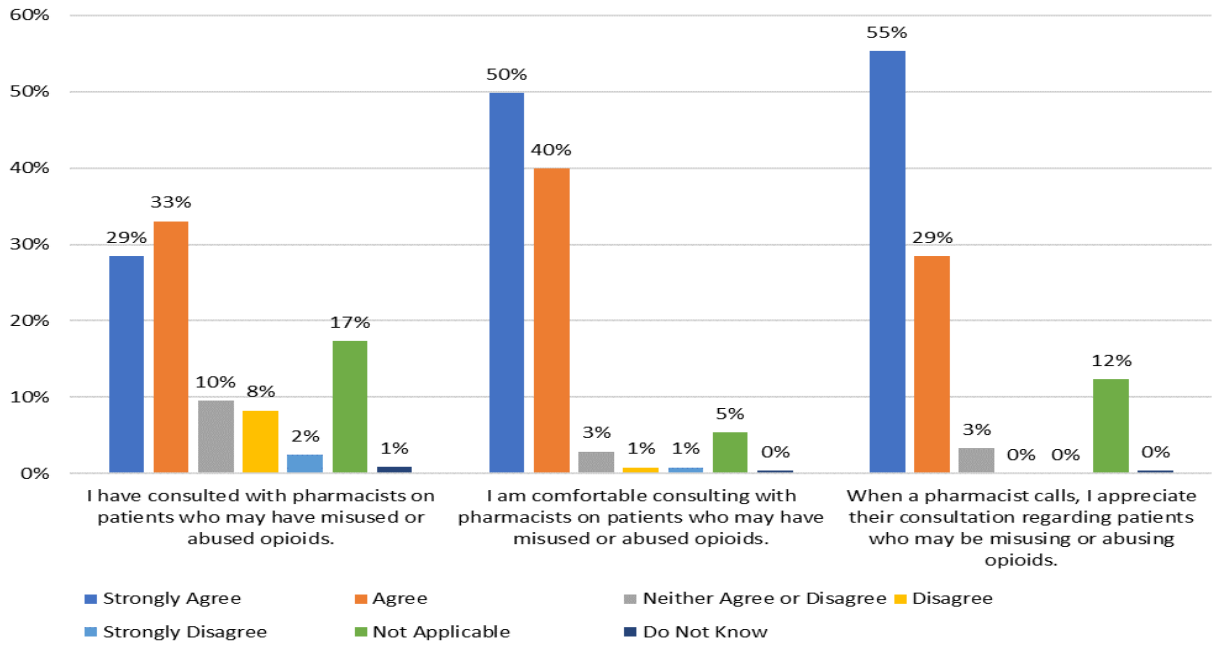
Pharmacists regarding their relationship with medical/dental providers. Eighty-nine percent (89%) are comfortable consulting providers, 62% believe their consultation influenced patient care, 67% believe they are respected by providers regarding alerting them potential misuse or abuse; 69% are comfortable informing providers of patients who have both benzodiazepine and opioid medications prescribed, and 64% are comfortable discussing reducing quantiles of opioid prescriptions with providers.

Figure 11: Pharmacists regarding medical/dental provider relationship



Medical/dental providers regarding pharmacist relationship. Ninety percent (90%) of medical and dental providers are comfortable consulting pharmacists on patients who may have abused or missed opioids and84% are appreciative of pharmacists' consultation.

Figure 12: Medical/dental providers regarding pharmacist relationship



For further data regarding professional relationships, refer to Appendices E – Pharmacists, F – Medical/Dental Providers, and G – Criminal Justice.

TREATMENT

Substance use disorder counseling and treatment agencies accredited by SD DSS were asked to respond to a set of prompts regarding the services that they provide that are accredited by the South Department of Social Services for both adults and adolescents.

A majority of the respondents reported not being at capacity within their agency and average wait times for services varied from 0-30 days depending on the treatment level of care.

Twenty-five (25) of the 30 agencies reported supporting an abstinence based approach; 22 supported a harm reduction based approach and three reported patient driven goals and a co-occurring treatment orientation.

The majority (28 of the 30 reporting) of the accredited treatment providers reported using the evidenced based modalities of Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI). Five agencies reported providing Medication Assisted Treatment however the type of MAT treatment was not captured.

Two agencies reported the capacity to deliver addictions treatment via telehealth through the Criminal Justice Initiative program that DSS-DBH supported originally as a pilot project but now is fully implemented across the state for individuals with justice system involvement and addiction issues.

Accredited treatment agencies reported providing the following levels of ASAM treatment including Early Intervention; Outpatient Treatment; Intensive Outpatient Treatment; Day Treatment; Clinically Managed Low-Intensity Residential Treatment; Social Detoxification; and Medically Monitored Intensive Inpatient Treatment.

There are 549 accredited residential beds in the state. Table 7 outlines by ASAM level.

Table 11: ASAM Number of Accredited Treatment Agency Beds

Accredited Service Type[1] ("ASAM" refers to "American Society of Addiction Medicine")	Number of Adult Beds	Number of Adolescent Beds
ASAM Level 2.5 Partial Hospitalization Services/Day Treatment Services	18	None Reported
ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services	313 (1)	None Reported
ASAM Level 3.2: Clinically-Managed Residential Detoxification Program (Social Detox)	50	None Reported
ASAM Level 3.7 Medically Monitored Intensive Inpatient Treatment Services	168 (1)	76 (2)

NOTES:

(1) Providers that have multiple levels of care, flex their beds based on patient need. For example, Volunteers of America has 14 beds total for adults; they use these beds for 3.7 and 3.1 levels of care.
(2) Note all "3.7" adolescent services are accredited as a Psychiatric Residential Treatment Facility as outlined by 42 CFR 441.152.

Accredited treatment agencies also provided a broad array of comments on what they felt would be most helpful for their opioid dependent patients. Comments included having access to inpatient followed by outpatient counseling and access to medication assisted treatment and coordination with medical providers.

[1] See https://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about for more information about American Society of Addiction Medicine (ASAM) criteria

WORKFORCE DEVELOPMENT and TRAINING

Counseling and Treatment Staffing. Accredited substance use disorder counseling and treatment agencies were asked the number vacant/open positions they had at their agency. At the time of inquiry in April 2017, 12 addiction counselor trainees, 3 certified addiction counselors, 6 licensed professional counselors, 1 licensed professional counselor, 5 LPC – mental health counselor, and 3 MSW- private or independent practice positions were open. Agencies were asked to indicate if they have had any issues filling open positions with professionals who obtained their license from another state. Individuals answering affirmatively were asked to identify which states responses. The following states were specifically noted (with one respondent also indicated issues with an applicant from Canada):

- Iowa (2 respondents)
- Minnesota (4 respondents)
- Nebraska (1 respondent)
- North Dakota (2 respondents)
- Wyoming (1 respondent)

Workforce Training. Survey respondents suggested training should be included in the opioid abuse strategic plan. Training suggestions included but were not limited to: additional education opportunities for therapists, MAT training, physicians and pharmacists working with law enforcement during fraudulent prescription investigations particularly HIPAA guidelines, prescription practices for pain management, and recognizing opioid abuse and misuse.